AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

February 22, 2012

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These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

Grant Announcements

Comprehensive Geriatric Education Program (CGEP),§5305. Announced February 16, 2012. Funding is available to develop and implement programs to train and educate individuals in providing geriatric care for the elderly. Eligible applicants are accredited schools of nursing, health care facilities, programs leading to the certification of certified nurse assistants, or partnerships of such schools and facilities. $4,220,000 is available annually to fund 16 grantees. The project period is 3 years. Applications are due March 26, 2012.
The announcement can be viewed at: HRSA

Guidance

2/17/12 CMS announced proposed payment and policy guidance for Medicare Advantage and Medicare prescription drug plans for 2013. According to CMS, the proposed guidance will continue the trend of lower premiums and stable or improved benefits for beneficiaries. CMS will exercise its authority under §3209 of the ACA to deny bids by Medicare Advantage organizations if it determines that the bid proposes a significant increase in cost sharing or a decrease in benefits from one year to the next. The Advance Notice and draft Call Letter also includes revisions to payment methodologies and policy and operational process updates for Part C Organizations and Part D Sponsors. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by

Medicare and provide both Part A (Hospital Insurance) and Part B (Medical Insurance) coverage. Medicare Advantage Plans may offer extra coverage, such as vision or dental; most include Medicare prescription drug coverage (Part D). Medicare pays a fixed amount for a member's care every month to the companies offering Medicare Advantage Plans and, per the ACA, plans can no longer charge higher cost sharing than what a member in traditional Medicare pays.
Read the press release: Press Release
Read the Advance Notice and draft Call Letter:
http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2013.pdf

2/17/12 HHS issued issuing a list of FAQs to provide additional guidance on HHS's intended approach to defining Essential Health Benefits (EHB), a package of medical services and treatments in at least ten broad categories of care that health plans offered through the Exchange and through the small/non-group are mandated to cover under §1302(a). In December HHS released a bulletin outlining proposed policies for states to implement this requirement. In the bulletin HHS describes the proposal as comprehensive, affordable and flexible. HHS intends to propose that essential health benefits are defined using a benchmark approach. Under the department's intended approach, states would have the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan."

The set of FAQs that HHS issued contains further information about the process of selecting and updating a benchmark, states' responsibility with respect to state-mandated benefits, and the application of benchmarks to plans that have enrollees in multiple states.
Read the FAQ's at: FAQ's

2/16/12 CCIIO is seeking comments on proposed consumer notices which would be distributed to consumers receiving rebates because their insurer failed to meet the medical loss ratio (MLR) standards required by ACA §10101. The MLR rules establish the minimum dollar percentage that health insurance companies must spend of consumers' health insurance premiums on medical care, not on income, overhead or marketing. Beginning in 2011, the ACA requires insurance companies in the individual and small group markets to spend at least 80% of collected premium dollars on medical care and quality improvement activities; insurance companies in the large group market are required to spend at least 85%.

Insurance companies that do not meet the MLR standard are required to provide a notice about their MLR as well as rebates to their consumers, making the first round of rebates the summer of 2012. CCIIO is also considering requiring insurers to notify consumers if their insurer did meet the MLR standard.

Comments and recommendations on the instructions and sample notices are due March 2, 2012.
Read the corresponding draft documents, including sample rebate forms at:
Documents
Or visit CCIIO's website at:
CCIIO Website (click on "CMS-10418")
For more information on the ACA's MLR provision visit:
http://www.healthcare.gov/news/factsheets/2010/11/medical-loss-ratio.html

2/10/12 DOL issued sub-regulatory guidance regarding the temporary safe harbor available to certain religious employers under the final rule that requires most health insurance plans to cover preventive services for women under ACA §2713. This includes recommended contraceptive services without charging a co-pay, co-insurance or a deductible in new private health plans in plan years that start on or after August 1, 2012. The

final rule, announced January 10, 2012, exempts organizations that are faith-based and primarily employ those of the same faith (such as churches, synagogues and mosques) from the requirement. In issuing the final rule the Secretary indicated that a one-year transition period or "temporary enforcement safe harbor" would be provided to non-exempted, non-grandfathered group health plans established and maintained by non-profit organizations with religious objections to contraceptive coverage.

The bulletin describes the temporary enforcement safe harbor. Read the bulletin at:
Bulletin
Read the final rule at:
http://www.gpo.gov/fdsys/pkg/FR-2012-02-15/pdf/2012-3547.pdf
Read a fact sheet on the new rule at:
Fact Sheet

Prior guidance can be viewed at www.healthcare.gov

News

2/21/12 CMS announced that seven CO-OPs will receive repayable loans to help them establish private non-profit, consumer-governed health insurance companies to offer qualified health plans in the health insurance exchanges.
Established under §1322 of the ACA, the goal of CO-OP program is to create a new CO-OP in every state in order to expand the number of exchange health plans with a focus on integrated care and plan accountability. Non-profits receiving loans include: Freelancers CO-OP of Oregon, New Mexico Health Connections, Montana Health Cooperative, Midwest Members Health, Common Ground Healthcare Cooperative, Freelancers CO-OP of New Jersey, and Freelancers Health Service Corporation. Starting in 2014, these CO-OPs will operate in Oregon, New Mexico, Montana, Iowa, Nebraska, Wisconsin, New Jersey, and New York.
CMS will continue to review applications and announce additional awardees on a rolling basis. For more information visit:
http://www.healthcare.gov/news/factsheets/2012/02/coops02212012a.html

2/17/12 CMS released two reports on the status of payments to plan sponsors of the Early Retiree Reinsurance Program (ERRP), a program authorized under §1102 of the ACA which provides reimbursement to participating employment-based plans for a portion of the costs of health benefits for early retirees and early retirees' spouses, surviving spouses, and dependents. The February reports reveal that the ERRP program will stop paying new claims.

In April 2011 CMS announced that, as of May 5, 2011, the agency was exercising its authority under §1102(f) of the ACA to stop accepting applications for the EERP, due to the availability of funds. The EERP fund was established to be available until 2014, when health insurance exchanges are operational and new rules are in effect to make it easier for older Americans to buy insurance without the help of an employer. Congress appropriated $5 billion for the program, butas of January 19, 2012, over $4.7 billion in funds had been spent.

In December 2011, when reimbursements surpassed the $4.5 billion mark, CMS said it would not pay claims incurred after December 31, 2011, although early retiree health care plan sponsors could continue to file for reimbursement of claims incurred through that date.

Read the February program status update at:
http://cciio.cms.gov/resources/files/Files2/02172012/errp_progress_report.pdf
Read the February Reimbursement Update at:
http://cciio.cms.gov/resources/files/Files2/02172012/errp-posting_feb2012.pdf

For more information, visit the ERRP site at: ERRP Site

2/16/12 HHS/CCIIO rejected a request from Wisconsin for a waiver which would have allowed insurers in that state to phase in the ACA's medical loss ratio (MLR) requirements and issued an altered adjustment waiver for North Carolina.

The ACA allows the Secretary to adjust the medical loss ratio (MLR) standard under §10101 of the ACA for a state if it is determined that meeting the 80% MLR standard may destabilize the individual insurance market. In order to qualify for this adjustment, a state must demonstrate that requiring insurers in its individual market to meet the 80% MLR has a likelihood of destabilizing the individual market and result in fewer choices for consumers. As part of the ACA, if insurers fall short of the standards in 2011, they'll have to issue rebates for that amount in 2012.

Wisconsin requested an adjustment to the MLR standard to 71%, 74%, and 77% for reporting years 2011, 2012, and 2013, respectively. HHS determined that that no adjustment to the MLR standard in Wisconsin was necessary because almost all of the insurers in the state's individual market either already meet the 80% threshold, are sufficiently profitable to provide rebate payments if they fail to meet the 80% MLR standard, or are adapting their business models in order to provide consumers better value for their premium dollar.

North Carolina requested an adjustment of the MLR standard to 72%, 74%, and 76% for reporting years 2011, 2012, and 2013, respectively. HHS granted an alternative adjustment waiver of 75% for 2011 only, with the 80% standard to apply in 2012 and 2013 in order to ensure market choice is preserved. According to data provided by the state, the individual health insurance market in North Carolina is highly concentrated with only nine issuers in the market, and one carrier with a market share of more than 80%. Although most issuers in the state individual market are adapting their business models in order to provide consumers better value for their premium dollar, meeting the 80% MLR standard would make it difficult for smaller issuers who would need to reduce marketing expenses necessary for them to compete.

HHS has approved adjusted waivers from New Hampshire, Nevada, Kentucky, Georgia, Iowa and North Carolina. Maine is the only state to receive full approval of their application. HHS has denied requests from Florida, North Dakota, Louisiana, Kansas, Delaware, Indiana, Michigan, Texas, Oklahoma and Wisconsin.In September HHS denied Guam's request saying the rules in question don't apply to the insurance markets in Guam. For more information on states and the MLR requirements visit the Center for Consumer Information and Insurance Oversight (CCIIO) website at: http://cciio.cms.gov/programs/marketreforms/mlr/index.html

2/16/12 The White House **highlighted a part of the President's fiscal year 2013 budget proposal that expands the ACA tax credit available to small businesses under ACA §1421** by about $14 billion over a decade so that it is easier for small business owners to provide insurance to their employees. The tax credit is designed to help small employers offer health insurance coverage for the first time or maintain coverage they already have. Currently, certain companies with 25 or fewer workers that pay for at least half of employees' healthcare coverage can claim progressively higher tax credits (up to 50% starting in 2014). The President's budget would increase the size of eligible companies to those with 50 or fewer workers, proposes more generous phase-out provisions and simplifies the credit, making it easier to claim. It is estimated that if the President's proposal were enacted, the tax credit will benefit about half a million employers who provide healthcare to 4 million workers in 2012 alone.

Read the White House blog entry at:
http://www.whitehouse.gov/blog/2012/02/16/expanding-healthcare-tax-credit-small-businesses

Learn more about the tax credit at: http://www.irs.gov/newsroom/article/0,,id=223666,00.html

2/15/2012 HHS announced that 54 million Americans with private health insurance received at least one **new free preventive service in 2011 under §1001 of the ACA**. In Massachusetts, an estimated 1,324,000 residents utilized these services which include colonoscopy screenings, pap smears, mammograms, well-child visits and flu shots. In addition, through §4103 and §4104 of the ACA, 32.5 million Medicare beneficiaries received at least one free preventive service in 2011. In total, an estimated 86 million Americans benefited from free preventive services last year due to the ACA.

Read the press release at:
http://www.hhs.gov/news/press/2012pres/02/20120215a.html
Read the report on expanded preventive benefits in private health insurance at:
http://aspe.hhs.gov/health/reports/2012/PreventiveServices/ib.shtml
Read the report on expanded preventive benefits in Medicare at:
http://www.cms.gov/apps/files/MedicareReport2011.pdf
Read the White House blog at:
http://www.whitehouse.gov/blog/2012/02/15/numbers-86-million

2/15/12 HHS Secretary Kathleen Sebelius testified before the Senate Finance Committee about President Obama's fiscal year 2013 budget proposal. Specifically she outlined HHS' $76.4 billion budget, spoke about how the budget supports ACA implementation and outlined several of the major initiatives in the ACA that will be funded by the $1 billion in discretionary funding allocated for CMS in the budget. The Secretary spoke about expanded and improved health insurance coverage that will be available through Affordable Insurance Exchanges as required under §1321 of the ACA. Since exchanges will be operational beginning in 2014, the Secretary spoke to how FY 2013 will be a critical year for building the infrastructure and initiating the business operations critical to enabling exchanges to begin operation on time. The Secretary spoke about how the budget will continue to fund the Partnership for Patients, an initiative launched in April 2011 that aims to improve the quality of healthcare by reducing preventable hospital-acquired conditions by 40% and preventable readmissions by 20% by the end of 2013, as compared to 2010. Her testimony also highlighted how the ACA strengthens the health care delivery system and reviewed the projects being funded by CMS' Innovation Center, established by §3021 of the ACA. The Secretary also spoke about the new office to coordinate care for duals authorized under §2602 of the ACA and how HHS is currently supporting 15 states (including Massachusetts) as they design models of care that better integrate Medicare and Medicaid services and how HHS is designing additional demonstrations to continue to improve care.
Read the Secretary's testimony at:
Testimony

2/15/12 Speaking at the Senate Finance Committee hearing about the President's fiscal year 2013 budget proposal, **Secretary Sebelius said that HHS will issue an additional final rule by August 2013 governing insurance coverage of contraceptive services and its application to self-insured employers**. Earlier this month HHS announced final regulations regarding §2713 of the ACA that guarantees women will have free preventive care that includes contraceptive services no matter where she works while protecting religious liberty and accommodating concerns raised by faith-based employers. ACA §2713 requires that most private health plans cover preventive services for women including recommended contraceptive services without charging a co-pay, co-insurance or a deductible in new private health plans in plan years that start on or after August 1, 2012. The previously announced rule exempts organizations that are faith-based and primarily employ those of the same faith (such as churches, synagogues and mosques) from the requirement. The rule allows a non-exempted religious organization to choose not to cover contraception and requires the employers' insurers

to directly offer the coverage to plan participants without any co-payments, co-insurance or deductibles. The employers, such as hospitals and charities, would not have to pay for the coverage or refer employees to organizations that provide such services.

However, HHS has yet to determine how its decision to broaden the exemption will address employers that self-insure. Sebelius said the additional rule will include more specifics and will address both insurance plans and self-insured groups. After the hearing the Secretary stated, "We will apply it to both - making sure that there are arrangements in place, so whether it's an insured plan or a self-insured plan, that the employer who has a religious objection does not have to directly offer or pay for contraception."

Employers that self-insure provide health insurance directly to employees, paying the health care claims of their workers. Large employers may choose to self-insure because they can spread the risk across hundreds or thousands of workers. The option is often more economical and can allow an organization to tailor its plan to the specific needs of its employees. Many such employers contract with an insurance company to administer the plan.

Read the final rule (published on 2/15/12) at:
http://www.gpo.gov/fdsys/pkg/FR-2012-02-15/pdf/2012-3547.pdf
Read the fact sheet on the finalized rule at:
Fact Sheet

2/14/12 HHS released a new report that shows that **joint DOJ-HHS health care fraud and prevention enforcement efforts recovered nearly $4.1 billion** in taxpayer dollars in fiscal year 2011. The money stolen or otherwise improperly obtained from federal health care programs was recovered and returned to the Medicare Trust Funds, the Treasury and others in FY 2011. The ACA provides tools and resources, including $350 million for Health Care Fraud and Abuse Control Program (HCFAC) activities. Currently, the Obama administration is implementing enhanced provider screening and enrollment requirements, increased data sharing across government agencies, expanded overpayment recovery efforts and greater oversight of private insurance abuses as authorized by Title VI, Transparency and Program Integrity of the ACA.
Read the press release: http://www.hhs.gov/news/press/2012pres/02/20120214a.html
Read the 2011 HCFAC Report Here:
http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2011.pdf

EOHHS News

2/16/12 MassHealth's final proposal for a State Demonstration to Integrate Care for Dual Eligible Individuals was submitted to CMS on February 16, 2012. CMS posted the proposal at
http://www.integratedcareresourcecenter.com/icmstateproposals.aspx on February 17. CMS is seeking public comment through a 30-day notice period. During this time interested individuals or groups may submit comments to help inform CMS' review of the proposal. To be assured consideration, **please submit comments by 5 p.m. EST, March 19**. You may submit comments on this proposal to MedicareMedicaidCoordination@cms.hhs.gov.

Upcoming Events

Integrating Medicare and Medicaid for Dual Eligible Individuals
Open Meeting External Event sponsored by the Massachusetts Medicaid Policy Institute: "Risk Adjustment for Integrated Care: Breaking New Ground for Dual Eligibles in Massachusetts"

Wednesday, February 29, 2012
9:00 - 9:30 AM Registration and Refreshments
9:30 - 12:00 Noon Program
Omni Parker House, Kennedy Room
60 School Street
Boston, MA
Space for this event is limited. Please register at:
Register
This forum is in follow-up to a report issued by Massachusetts Medicaid Policy Institute (MMPI), a program of the Blue Cross Blue Shield of Massachusetts Foundation. The report examines the critical need for risk adjustment in programs serving persons dually eligible for Medicare and Medicaid, and describing federal and state experience implementing risk adjustment models. The report is available at: Risk Adjustment for Dual Eligibles: Breaking New Ground in Massachusetts.

Quarterly Affordable Care Act Implementation Stakeholder Meeting
Monday, March 12, 2012 from 2PM- 3PM
1 Ashburton Place, 21st Floor
Boston, MA

Bookmark the **Massachusetts National Health Care Reform website** at: http://mass.gov/national health reform to read updates on ACA implementation in Massachusetts.

Remember to check http://mass.gov/masshealth/duals for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.